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8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No.

2010-95

13 **ROLLY SANTOS SOLIMAN**
11016 Kittridge St., Apt. 2
14 North Hollywood, CA 91606
Registered Nursing License No. 613009

A C C U S A T I O N

15 Respondent.

16
17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
20 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department
21 of Consumer Affairs.

22 2. On or about February 3, 2003, the Board of Registered Nursing (Board) issued
23 Registered Nursing License Number 613009 to Rolly Santos Soliman (Respondent). The
24 Registered Nursing License was in full force and effect at all times relevant to the charges
25 brought herein and will expire on July 31, 2010, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. Section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

7. Section 2811(b) provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

9. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of

1 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
2 enforcement of the case.

3 **CAUSE FOR DISCIPLINE**

4 **(Gross Negligence)**

5 10. Respondent is subject to disciplinary action under section 2761, subdivision (a), in
6 conjunction with California Code of Regulations, title 16, section 1442, as a result of
7 Respondent's delivery of care in a manner that represented an extreme departure from the
8 standard of care which, under similar circumstances, would have ordinarily been exercised by a
9 competent registered nurse.

10 a. On or about May 6, 2007, while working as a registered nurse at Glendale Memorial
11 Hospital (Glendale Memorial) in Glendale, California, Respondent mistakenly administered an
12 unfamiliar medication through an intravenous line, and this mistake resulted in a patient's death.

13 b. The incident involved a 71-year old female patient with stage IV cancer (the patient)
14 that had metastasized to the lungs. The patient was suffering from pleural effusion, an excess of
15 fluid in the pleural cavity surrounding the right lung. To address the pleural effusion, a Glendale
16 Memorial Pulmonologist, Dr. Wen, had arranged for the patient to undergo a talc slurry
17 pleurodesis, a procedure which would introduce a sterile solution of talc and saline (to prevent
18 fluid buildup) into the pleural cavity via a chest tube .

19 c. On May 6, 2007, Dr. Wen wrote an order for this talc slurry. Dr. Wen's handwritten
20 order did not indicate frequency or route information, and Respondent, who was unfamiliar with
21 this procedure., misread the handwritten letters "IN" to be "IV/" Although Respondent was
22 unfamiliar with the medication and administration, based on his reading of the order, and the
23 pharmacy's subsequent loading of the medication into an IV-compatible "leur lock" tip in error,
24 Respondent administered the medication through the patient's IV line. Within a short time, the
25 patient began to shake, turned blue, and lost consciousness. Although resources existed at
26 Glendale Memorial which would have enabled Respondent to familiarize himself with the talc
27 slurry pleurodesis procedure, its indications, contraindications, and dangers, Respondent failed to
28 do so.

d. Respondent failed to educate himself about the drug before administering it to the patient.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nursing License Number 613009, issued to Respondent;

2. Ordering Respondent to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED:

8/19/09

Louise R. Bailey
 LOUISE R. BAILEY, M.ED., RN
 Interim Executive Officer
 Board of Registered Nursing
 Department of Consumer Affairs
 State of California
 Complainant

LA2008602180